# Barney Family Dental

David M. Barney, DMD

Welcome to Barney Family Dental and thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care and achieve the smile you desire. To help us meet all your dental healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask – we are happy to help!

Date:

## PATIENT INFORMATION

Name: _____ Preferred Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Receive Text Reminders? Y___ N___ Status: Single: ___ Married: ___ Divorced: ___ Widowed: ___ Other: ___

Date of Birth: _____ Age: _____ Social Security Number: _____ Sex: M___ F___

Email (contact purposes only): _____ Receive Email Reminders? Y__ N__

Whom may we thank for referring you? _____

## FINANCIAL INFORMATION

Person Financially Responsible: _____ Date of Birth: _____ SSN: _____

Employer: _____ Occupation: _____ Phone: _____

Which method of payment do you intend to use for treatment? Insurance___ Cash/Debit___ Credit Card___ CareCredit___

**EMERGENCY CONTACT:** _____

Phone Number: _____ Relationship to Patient: _____

## DENTAL INSURANCE INFORMATION

**PRIMARY CARRIER**: _____ Phone: _____ Employer: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Subscriber's SSN: _____ Group #: _____ ID#: _____

**SECONDARY CARRIER**: _____ Phone: _____ Employer: _____

Subscriber: _____ Date of Birth: _____ Relationship to Patient: _____

Subscriber's SSN: _____ Group #: _____ ID#: _____

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# FINANCIAL POLICY & CONSENT FOR TREATMENT

The following is a statement of our Financial Policy and Consent for Treatment, which we require you read and sign prior to any treatment performed. Please let us know if you have any questions.
Thank you!

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**FULL PAYMENT IS DUE AT THE TIME OF SERVICE**

We realize every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed, with respect to your budget. Please note however, that payment in full is expected at the time of service. Barney Family Dental gladly accepts cash, checks, all major credit cards, and CareCredit. We provide a 5% courtesy discount for noninsurance patients who pay by cash or check. **There is a $25.00 fee on all returned checks**. NSF checks must be redeemed with certified funds (money order, cashier's check, or cash).

**DENTAL INSURANCE**

As a courtesy, our office is happy to prepare and bill your insurance to collect payment directly from them. However, we cannot guarantee any estimated coverage. Your insurance policy is an agreement between you and the provider; therefore, we ask that all patients be directly responsible for all outstanding charges. If for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you will be held responsible for payment at that time.
Our office is unable to bill medical insurance. If you believe you have coverage through your medical plan, we will collect the full cost of treatment and provide you with any necessary documentation to bill your medical insurance for reimbursement.

**CONSENT FOR TREATMENT**

I hereby authorize Dr. Barney or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs.
Upon such diagnosis, I authorize Dr. Barney to perform all recommended treatment mutually agreed upon by me, and to employ such assistance as required, to provide proper care.
I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
I give consent to Dr. Barney or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. This may include outside dental offices requesting x-rays, periodontal charting, or other records on my behalf. I understand that only the minimum amount of information necessary to provide quality care will be used to disclose and that a notice fully outlining the protection of my personal health information is available to me.

**MISSED & CANCELLED APPOINTMENTS**

Per our office policy, Barney Family Dental reserves the right to charge **$50.00 for missed and cancelled appointments with less than 24 hours notice**. With respect to our office and the patients we care for, please help us better serve you by keeping your scheduled appointments. Please note, Dr. Barney reserves the right to dismiss patients who habitually cancel and/or miss their appointments.

**ACKNOWLEDGMENT**

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that all dental services are directly billable to the patient, regardless of insurance status, and **payment is due, in full, at the time of service** unless other arrangements have been made in advance. In the event payments are not received by the agreed upon dates, I understand that a 1.75% monthly finance charge (21% per year), will be added to any remaining account balance over 90 days. If required, I also understand a check of my credit history may be obtained.
If I do not pay my account in a timely matter, I understand that my account may be turned over to a 3rd party collections agency and I will be responsible for all legal costs and expenses in the pursuit of my delinquent account. I hereby authorize Barney Family Dental to release information necessary to secure payment. In the event that my debt is sent to a 3rd party collections agency I am aware that my family and I may be dismissed as a patients.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

_____
(PLEASE PRINT FULL NAME)

X_____ Date: _____
(Patient or Responsible Party Signature)

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# Consent for Use and Disclosure of Health Information

**SECTION A: PATIENT GIVING CONSENT**

Patient's Full Name: _____

**SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS.**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. This may include outside dental offices requesting x-rays, periodontal charting, or other records on your behalf. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: **Barney Family Dental**
Telephone: **(503) 579-2812** Fax: **(503) 579-6435**
E-mail: **info@barneydental.com**
Address: 14780 SW Osprey Drive, Ste 200, Beaverton OR 97007

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

**ACKNOWLEDGMENT**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this form, I am giving my consent for the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. I knowingly give consent for my insurance carrier to pay Barney Family Dental directly for any treatment rendered.

**Signature**: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

*REVOCATION OF CONSENT*
I revoke my Consent for your use and disclosure of my protected health information and treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

Signature: _____ Date: _____